MEDICAID NURSING HOME REIMBURSEMENT SERIES

VOLUME 3

Medicaid Nursing Home Reimbursement in Illinois

Bruce Spitz
Jane Weeks

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Bruce Spitz
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An Urban Institute Paper

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FOREWORD

This series, the "Medicaid Nursing Home Reimbursement Series," is part of an ongoing program of research at The Urban Institute on long-term care. Several studies of the nursing home industry and other components of the long-term care system have recently been conducted. Particular emphasis has been placed on the role of public policy in affecting the users and suppliers of care in this increasingly important part of the health sector.

The rise in national nursing home expenditures has been extraordinary by any standard. Nursing home expenditures increased from $480 million in 1960 to $15.8 billion in 1978. They increased by 17.9 percent annually from 1960 to 1966, by 23.8 percent annually from 1972 to 1978. While some of the growth in nursing home expenditures is due to an increase in patients, most of the increase is due to growth in expenditures per resident. For the ten-year period ending in 1977, total expenditures increased by 20.3 percent per year. For the same period, the number of residents grew at an annual rate of 5.4 percent and expenditures per resident by 14.9 percent annually.

The rise in expenditures per resident reflects considerably more than increase in input or factor prices. As measured by a market basket index constructed for skilled nursing facilities (SNFs) by the Health Care Financing Administration, input prices rose by 37.8 percent or 8.0 percent per year. During the same period, costs per patient day for skilled nursing facilities rose by 90.7 percent (from $15.58 to $29.71) or 16.1 percent annually. Rates of increase in costs per day that exceed the rate of increase in prices nursing homes must pay reflect either growth in the quantity of inputs or excessive payments for inputs or both.

As one might expect, Medicaid nursing home expenditures have also experienced rapid growth. In fiscal 1974, national Medicaid expenditures on SNFs and intermediate care facilities (ICFs) were $2.0 billion and $1.4 billion respectively. By fiscal 1977, expenditures had risen to 2.8 billion for SNFs and 2.6 billion for ICFs. Payments by state Medicaid programs account for approximately 50 percent of expenditures for nursing home care and pay some portion of the daily cost for approximately 70 percent of nursing home residents. Thus, we believe that the influence of Medicaid policy, particularly nursing home reimbursement policy, is enormous. Rising expenditures for Medicaid programs generally have forced states to consider every option for cost control. In this series, we describe and analyze the systems adopted in three states: New York, Minnesota, and Illinois.

Controlling inflation is not the only objective of nursing home reimbursement policy. There is also concern at both the state and federal levels that reimbursement policy promote acceptable quality care and an adequate supply of beds. The Section 249 regulations, which became effective on January 1, 1977, required states to pay on a reasonably cost-related basis. The objective of these regulations was to require states to pay for the full costs of providing routine services in an efficient manner. The intention ostensibly was to assure full payment for homes that efficiently provide good quality care.

Section 249 has in practice given states considerable latitude in designing reimbursement policies. Thus states can design systems which are primarily concerned with controlling costs and which pay little attention to the problem of quality. Nonetheless, reimbursement policy can have important implications for quality of care, simply because one nursing home response to payment limits is a reduction in quality.

Assuring an adequate supply of beds for Medicaid patients may also be an objective of reimbursement policy. Because of Medicaid's importance in the industry the generosity of payment rates affects decisions to open new homes or expand bed capacity of existing homes as well as the number of existing beds allocated to Medicaid vis-à-vis Medicare or private beds. The problem of access goes beyond the availability of beds to Medicaid patients. A limited bed supply can also affect who is admitted to nursing homes. That is, it may

be difficult to place patients with heavy care needs. These patients may either remain in hospitals or be sent home while patients with less intensive care needs are admitted.

Another problem frequently addressed by nursing home reimbursement policy is excessive property cost reimbursement. In the late 1960s and early 1970s, there were frequent occurrences of extraordinary profits made through sales with leaseback arrangements, ownership turnover to increase the property base for reimbursement, excessive interest expenses, etc. Many state systems contain features which specifically discourage or prevent manipulation of nursing homes by real estate investors.

In this series, Bruce Spitz and Jane Weeks have attempted to carefully identify and assess the various incentives in these states' reimbursement systems. The implications of each state's reimbursement policy for cost containment, quality of care, access for Medicaid patients, and control of real estate manipulation are addressed. In work now proceeding at The Urban Institute, we are attempting to empirically test many of the hypotheses proposed in these papers. Data from these states as well as several others are being analyzed.

John Holahan, Director
Health Policy Research Program

PREFACE

The nursing home industry is the only major component of the medical sector which has become a Medicaid industry. Long-term care facilities are dependent upon the state for most of their patients and their revenues. Because of this high level of dependency and because of the importance of payment systems to the survival of the industry, nursing home reimbursement policy is the most powerful device the state has at hand. With it, the state can influence, to a large extent, the location of firms, the size of homes, the dominance of proprietary or nonprofit (voluntary) homes, the general availability of beds, and the levels of care available. It can encourage or discourage certain real estate transactions, patient transfers, and the delivery of specific types of care. Reimbursement policy, in short, permits the state to define and develop the type of industry it wishes to care for its Medicaid patients and, to a lesser degree, its nonimpoverished citizens.

Under financing from the Health Care Financing Administration (HCFA), we have attempted to analyze the way in which reimbursement policy has been made and applied at the state level. Specifically, we examined the politics and economics of nursing home reimbursement in seven state Medicaid programs: California, Colorado, Connecticut, Illinois, Louisiana, Minnesota, and New York. Within each state, we collected reports, memoranda, testimony, position papers, and other relevant data related to the development of that state's reimbursement system. We also interviewed approximately fifteen individuals per state who played a role in the development of the payment mechanisms. The respondents were typically administrators within the state's department of social services, department of health, and department of management and budget; the state legislators and

their staffs; and executives, lawyers, and/or accountants representing the state's nursing home associations.

The information collected was assembled, analyzed, and presented as seven case studies. Each case study was sent to the federal Medicaid agency, the relevant HCFA regional office, and the state respondents for review and criticism. Nearly all of the comments received were incorporated into the state reports.

As a result of all of this, we were able to present an accurate account of how individual Medicaid rate-setting mechanisms developed. The information permitted a detailed review of the political concerns, the technical problems, and the economic implications that accompanied the discussions, design, and implementation of the reimbursement systems. Though the size of the sample and the complexity of the topic prevent us from making many generalizations from our case studies to the rest of the country, there are two types of results which have very useful policy implications. The first is that most of the states faced common reimbursement problems. The second is that those common problems often have many possible solutions. Among our sample states each reimbursement solution represented an attempt to merge technical and political considerations within the historical, political, and economic context of the state's Medicaid program and nursing home industry. A successful solution in one state, therefore, would not necessarily bring about similar results in another state. An understanding of one state's experience, however, would permit others to assess the similarity of the conditions, the relevance of the policy and procedures, the likelihood of encountering the same impediments and pitfalls, and the probability of success.

This series presents the experience of three states: New York, Minnesota, and Illinois. These states were selected because they experimented with a large number of reimbursement approaches. They displayed a high level of complexity and inventiveness. And, they frequently acted as models for other states.

The series is the product of a good deal of time, attention, and cooperation of a large number of individuals: respondents at the state level and regional offices, federal administrators, and friends

in academia. While we take complete responsibility for any errors in interpretation or communication, we wish to offer our thanks to all those who were involved in the project. We are particularly indebted to three of our colleagues at The Urban Institute: to William Scanlon for his detailed critiques, observations, and insights into the economics of the nursing home industry, the dynamics of the reimbursement system in general, and the nature of capital reimbursement and the real estate market in particular; to Judith Feder for her careful and perceptive comments on political trends and institutional behavior and her ability and willingness to detect factual and logical errors; and to John Holahan for his lengthy and comprehensive reviews, his observations on the economic and political dynamics of the nursing home industry and the Medicaid program, and his ability to ferret out inconsistencies and suggest alternative causes and implications. Finally, we must acknowledge an intellectual debt to William Pollak. His work on nursing home reimbursement not only established the foundation for this effort but, over the past few years, has structured policy discussions in many of the states.

Bruce Spitz
and Jane Weeks

I. INTRODUCTION

Medicaid nursing home reimbursement policy in Illinois has developed in response to generally conservative fiscal state policies and a preference among state officials for linking a measure of patient debility with payment. The policy and the reimbursement system have remained unusually stable. From its inception in 1967 to 1978 when it was incorporated into a cost-related system, the point count reimbursement used in Illinois remained basically unaltered. It consisted of a base rate (adjusted for special services) and point rate derived from an evaluation of the patient's level of debility. The stability of the system was due in part to quality of care scandals in the early 1970s which led to innovative and active monitoring of care but which also directed attention away from the payment mechanism. Stability was also related to the point count's "flexibility." This allowed providers to survive and expand even though rates were effectively frozen for extended periods of time.

The 1978 cost-related system used the "point count" to reimburse nursing costs only. The remaining operating costs were reimbursed up to the cost experience of the fiftieth percentile of skilled care and intermediate care facilities within a given geographic area. Capital costs were determined by aggregating homes by age and location and reimbursing according to the group experience within each cell.

In this paper we attempt to evaluate the development of the payment mechanism and analyze the incentives within various parts of the system. We will examine the direction of these incentives, the possible outcomes, and the potential regulatory response to those results. We shall focus on the point count component of the methodology because it was the most innovative part of the system and because it has become a model for other states attempting to link quality of care to reimbursement.

II. THE ILLINOIS NURSING HOME INDUSTRY

In 1977, there were 939 long-term care facilities with 97,620 beds in Illinois. The 364 homes classified as skilled nursing facilities (SNFs) represented 38,678 licensed beds; 400 intermediate care facilities (ICFs) and 175 sheltered care homes accounted for 58,051 licensed beds. In addition, 891 beds had provisional licenses (table 1). SNFs ranged in size from 21 to 324 beds, ICFs from 8 to 300 beds, and sheltered care homes from 5 to 704 beds.[1] The average size for SNFs was 106 beds and 101 beds for ICFs with 61 percent of all facilities under 99 beds (table 2).

Table 1

Long-Term Care Facilities and Beds, March 1977

Level of Care	Downstate	Cook County	Total
SNF: beds	23,024	15,654	38,678
ICF-I: beds	28,417	13,530	41,947
ICF-II (sheltered care): beds	10,918	5,186	16,104
Provisional: beds	891	0	891
Total beds	63,250	34,370	97,620
Total facilities	694	245	939
Average facility size	91.1	140.3	104.0

Table 2

Facility Size Distribution, March 1977

Number of Beds	Number of Facilities
0 - 49	238
50 - 99	340
100 - 149	170
150 - 199	82
Over 199	109
Total	939

Ownership patterns reflected domination by the proprietary sector; nearly 82 percent of the facilities were for profit, 14 percent were private, nonprofit, and slightly more than 4 percent were run by county governments (table 3).

Table 3

Long-Term Care Facilities by Type of Ownership, March 1977

Type of Ownership	Downstate	Cook County	Total
County	40	0	40
Hospital district	5	0	5
Church operated or affiliated	48	31	79
Other nonprofit	33	15	48
Individual proprietorship	90	10	100
Partnership	67	30	97
Corporation	326	149	475
Trust	23	3	26
Out of state corporation	56	2	58
Unknown	6	5	11

Source: The following is the source for tables 1, 2, and 3: Illinois Department of Public Health (unpublished, undated).

As might be expected, a major portion of the industry was located in Chicago and the surrounding communities of Cook County. Nearly 48 percent of the citizens of Illinois and 47 percent of its elderly population reside in Cook County. However, Cook County's 245 long-term care facilities represented only 35 percent of the beds in the state and less than 41 percent of the SNF beds. Facilities tended to be larger in Cook County than Downstate (140 beds compared to 92 beds) and more expensive.

As in most states, Medicaid has been the major purchaser of long-term care in Illinois. In fiscal year 1976, state payments to nursing homes amounted to more than $208 million, representing 27 percent of the total Medicaid budget of $771 million.[2] Approximately 49,200 Medicaid recipients received care, 11,200 in SNFs, 30,500 in ICFs, and 7,400 in sheltered care homes.

Data concerning Medicaid's share of total industry revenues are imprecise. Assuming that all Medicaid patients stayed in the homes for a full year, that the private rates were equal to the Medicaid rates (which were, in June 1977, an average of $19.77 a day for SNFs and $15.64 a day for ICFs) and that the homes' yearly census equaled Medicaid's 93 percent imputed occupancy rate, then in 1976 Medicaid reimbursed and regulated a maximum of 54 percent of the industry's total revenues. Those assumptions are, of course, mildly heroic. Regardless of the exact percentage, Medicaid's financial involvement in nursing homes was considerable.*

State control extended well beyond the determination of rates. Illinois's regulation of nursing homes was divided among the Department of Health (DPH) and the Department of Public Aid (DPA), the

* If Medicaid patient length of stay was less than a year, then the 49,200 Medicaid patients represented fewer than 49,200 patient bed years; that is, they filled fewer than 49,200 of the 97,620 beds. If private-pay rates exceeded Medicaid rates (and both state and industry surveys and studies clearly indicate that they do), then the number of Medicaid patients overrepresented their revenue potential. Finally, if the industry's occupancy level exceeded the imputed 93 percent level, beds assumed to be empty would have been filled with private-pay patients and Medicaid's revenue share will be overestimated. If the occupancy levels were less than 93 percent, Medicaid would not have reimbursed its proportionate share of fixed costs and again, Medicaid revenues would have been less than 54 percent of the industry's total revenues.

Department of Mental Health Developmental Disabilities (DMH), the Health Facilities Planning Board, and the fire marshal's office within the Department of Law Enforcement.

DPH was responsible for setting nursing home standards, inspecting homes, certifying ICFs and SNFs, and initiating enforcement proceedings. In addition, the DPH Office of Health Finance, a special agency created by executive order in 1971, was responsible for "determining the rates at which state agencies and departments purchase health care services (and) collecting, analyzing, and disseminating to state agencies and departments such data on health care costs, supply and demand for health service and economic trends as is necessary for rate determination (and)...conducting the functions of negotiations, determination, review and evaluation in such a way as to assure that health care services are purchased in the most economical manner consistent with the quality of care and with state and federal statute and legislation."[3] The Office of Health Finance has played a central role in the development of the most recent nursing home reimbursement system.

DPA was responsible for determining eligibility of Medicaid recipients, utilization review for ICF patients, auditing nursing homes, processing nursing home claims, and reimbursement. DMH directed its energies towards monitoring the long-term care received by those with mental health problems. The Health Facilities Planning Board was primarily concerned with issuing certificates of need for new or expanded long-term care beds or for changes in the existing stock. The fire marshal was charged with inspecting homes and certifying their compliance with the federal and state fire and safety standards. In addition, counties often ran their own homes and licensed facilities within their boundaries.

ILLINOIS MEDICAID REIMBURSEMENT

From 1967 to 1978, Illinois Medicaid reimbursed nursing homes on a "point count" system. This reimbursement mechanism consisted of four components: a base rate, a shelter factor, an add on, and a point-based patient evaluation.[4] The base rate was an arbitrarily set

minimum payment which varied by licensed level of care and geographic region (Cook County and St. Clair County received slightly higher rates than the rest of the state). The shelter factor was an additional monthly payment made if the nursing home's physical plant met certain specifications — particularly the Life Safety Code requirements. All SNFs, new ICFs, and many of the remaining ICFs received this payment. If a facility had approved rehabilitation, activity, and social rehabilitation programs, it received an additional per patient payment (an add on) for each service it provided. The fourth component was based on evaluation of the individual patient. This evaluation consisted of a caseworker's rating recipients according to a seventeen-item checklist covering a patient's ability to perform daily living activities as well as a patient's mental status and nursing needs. Each item was ranked according to the level of debilitation and assigned a point value. The greater the devility, the greater the number of points. The point count ranged from zero to fifty. Each point represented a given dollar amount.

In 1977, Illinois's average Medicaid per patient day payment to SNFs was $19.77 and to ICFs, $15.64. Illinois's rates were low in comparison to state payments within the rest of the North Central region as well as the nation (table 4). Of the thirty-two states reporting in 1977, nineteen paid higher average SNF rates and twenty-four higher ICF rates.*

In March 1978, Illinois received HEW approval for a new cost-related reimbursement system. This payment methodology grouped costs into three categories: support costs (laundry, dietary, housekeeping, utilities, and administrative expenses), nursing costs, and capital costs. Support costs are reimbursed up to the fiftieth percentile of all SNFs and ICFs within a given geographic region. Facilities with support costs below the fiftieth percentile retained one half of the difference between their costs and the cost ceiling. Nursing costs were reimbursed by type of facility (SNF, ICF, ICF/Mentally Retarded, SNF/Pediatrics) according to the state's established point count evaluation of the patient's level of debility. Operating costs (support and nursing costs) were also adjusted to reflect changes in

* Because the states' rates were unadjusted for differences in case-mix, wages, the costs of land and building etc., this ranking should not be viewed as absolute measurement of relative payment levels in Illinois.

Table 4

Average Medicaid Nursing Home Reimbursement Rates, First Quarter, 1977

State	SNF	ICF
Illinois	$19.77	$15.64
Indiana	25.66	19.05
Kentucky	29.37	15.00
Minnesota	20.26	16.90
Missouri	16.10	14.92
Ohio	20.50	17.50
California	20.17	16.05
New York	37.09	27.03

Source: "Program Rate Update, First Quarter, 1977" Memorandum from Wayne Franklin, CPA, to the American Health Care Association State Executive Directors, April 15, 1977.

the CPI and minimum wage increases. Capital costs were reimbursed by aggregating homes into twenty-five categories (five geographic regions by five facility age groupings), adjusting those costs if a home's occupancy rate was below 93 percent, and calculating a median capital cost per bed figure. Those homes with capital costs at or below the median received the median payment. Those above received the median plus 80 percent of their costs up to 110 percent of the median.

III. THE DEVELOPMENT OF REIMBURSEMENT POLICY

SCANDALS AND IMPROVED STATE REGULATION

In 1967, Illinois adopted its point count reimbursement system. That payment mechanism remained intact for more than a decade despite recurring objections by different nursing home associations, task force recommendations, a boycott over rates, and surveys indicating that Medicaid rates frequently did not cover costs. Three factors rendered these forces for change ineffective: periodic and heavily publicized nursing home scandals, generally conservative state fiscal policies, and the flexibility of point count reimbursement.

The first major Medicaid nursing home scandal occurred in 1971, when the Chicago Tribune, aided by the Chicago Better Government Association, had four reporters apply for work as mopboys and nurses' aides in twenty-one Chicago area nursing homes. After six weeks of field work, the Tribune ran a seven-part series in early March 1971 which revealed instances of patient neglect and abuse, unsanitary physical conditions of the homes, improper use of personnel, and ineffective enforcement of regulations.[5] As the series unfolded, governments at all levels responded. A few of the homes discussed in the Tribune were closed immediately by the Chicago Board of Health.[6] The Illinois Department of Public Aid (DPA) terminated Medicaid payments to some of the homes.[7] The director of the Illinois Department of Public Health (DPH) personally performed surprise inspections.[8] Mayor Richard Daley ordered an immediate upgrading of nursing home requirements and an increase in facility

inspections in Chicago.[9] The Chicago Board of Health, the Illinois State Legislative Advisory Committee on Public Assistance, and the United States Senate Select Committee on Aging convened separate hearings in Chicago on nursing homes.[10] For a short period, those involved accused each other of allowing the scandal to occur. The state blamed Chicago for inadequate regulation and chastised itself for issuing nursing home licenses on the basis of Chicago Board of Health recommendations alone.[11] Chicago blamed the state for overloading nursing homes by dumping thousands of mentally retarded patients into the city's long-term care facilities (as authorized under the Illinois 1969 Copeland bills which mandated massive "deinstitutionalization" of patients in state mental hospitals).[12] The legislature blamed the nursing home associations for not monitoring the care delivered by their members.[13] The associations responded by saying that that was not their responsibility. In addition, the director of the Metropolitan Chicago Nursing Home Association charged that the "community gets what it deserves ... state government is simply not providing enough money for adequate staffing and care."[14] A representative for the Illinois Association of Homes for the Aging — a nonprofit association — further charged that its members could "no longer afford (or find other resources for) providing care for elderly Public Aid recipients for whom they receive payment in an amount substantially less than their actual costs. The remedy is singular — more money."[15]

Regardless of the nursing home associations' efforts to link poor quality with insufficient payments, public officials treated the quality of care issue as if it were unrelated to reimbursement. Poor government regulation was perceived as the cause. One reason for this was that the Tribune's exposé suggested that a majority of the homes were operating in gross violation of standards and that this was the result of inadequately staffed, incompetent, and/or corrupt public agencies. This view was reinforced by the DPH admission that more than 50 percent of the nursing homes in the state failed to meet minimum standards.[16] Public officials also blamed the operators and the shortage of beds for the unsatisfactory conditions of some of the homes without directly linking the bed shortage or unsatisfactory conditions to reimbursement. For example, the immediate response to the commissioner of the Chicago Board of Health to the nursing home scandal was "there are people that should not be in this business but

they are and it's difficult to keep them out. If you close them down, where are you going to put the people in the homes? It is not our purpose to close homes down. It's our purpose to care for people."[17] Further, as long as some high quality homes could be found rendering good care for the Medicaid rate, it could be argued that payment was adequate (although without adjusting for the cost of inputs within an area, the percentage of non-Medicaid patients in the home, or the private-pay rates in the facility, any comparison of homes is suspect).

The state interpreted reactions to the scandals as a political mandate to regulate the care provided in the homes. Governor Ogilvie responded by appointing a special deputy director of DPH to eliminate or upgrade substandard homes.[18] Within a year, the state had developed and implemented a client/provider information system capable of generating data on nursing homes (e.g., ownership, bed capacity, past violations, etc. and basic data on the location and medical reviews of public patients), which scheduled inspections automatically, informed inspectors what to look for, and processed memos to the homes after the inspections officially informing the facilities of violations and the time that the homes had to correct them.[19] In order to use this information system properly, the state added forty-three inspectors to DPA staff. By February 1972, sixty-two homes voluntarily closed because they were unable to comply with standards, thirteen voluntarily changed to a lower level of care, five had their licenses revoked, and thirty-one had DPA payments withheld until they complied with regulations.[20]

The state's regulatory effort was substantial but it did not eliminate or discover all questionable behavior in the industry. In March 1972, the Chicago Better Government Association joined with the Chicago Sun Times to expose conditions of patient abuse among mentally retarded patients placed in large sheltered care homes in Chicago's "uptown" district.[21] The mentally retarded/sheltered care scandals focused public attention on alleged failures by the state to monitor the care delivered. Once again, the state was forced to justify policies and procedures. Two months later, the Carver Nursing Home in Springfield burned down. Ten of the forty-one residents died. The fire produced more public indignation because the Carver home had been charged with providing poor care in 1971 hearings held by the Subcommittee on Long-Term Care in Chicago.[22]

The bad publicity received by nursing homes may have made discussions with the state about reimbursement impossible. Before the 1971 scandals, the state agreed to a 15 percent increase in the rate. After the Tribune exposé the increase was rescinded.[23] In 1972, the state agreed to a 12 percent increase in base rates but only half of that increase was actually implemented in July 1972, two months after the Carver Nursing Home fire.[24]

The nursing home industry's bad press also made it a part of the gubernatorial race. During his bid for reelection, Governor Ogilvie made a point of reviewing the success he had had in improving nursing home care. Between January 1972 and October 1972, 109 nursing homes were closed down for failure to meet minimum standards.[25] From September 1971 to September 1972, DPH conducted 3,349 surveys of the state's homes,[26] more than 3 surveys per home. The state found that 96 percent of the homes complied with administration standards, 94 percent with standards for medical and personal care, 95 percent with nursing standards, 96 percent with food service standards, and 94 percent with maintenance and housekeeping standards.[27]

KICKBACKS, SHELTERED CARE UPGRADED, AND BOYCOTT

Although nursing homes were discussed, taxes were the primary issue in the 1972 gubernatorial election. Ogilvie's successor, Daniel Walker, was elected on a platform featuring promises to cut taxes and contain state expenditures.[28] His administration became known for its conservative fiscal policies. For example, between 1972 and 1976, the state's total general revenue and common school fund expenditures remained the same in constant dollars.[29] Reimbursement for SNFs increased sixty-one dollars per patient month during the Walker administration, an average increase of fifty cents per patient day per year of his term.[30] In constant dollars, the base rate for SNFs was lower in 1976 than it was in 1972.

Nursing homes remained a prominent issue throughout the Walker administration. In 1974, the discovery of provider fraud within Medicaid produced evidence of massive kickback schemes between a small

number of nursing home operators and pharmacists. Governor Walker responded by creating a task force, headed by Dr. Joseph Wells, dean of Loyola University's School of Medicine to examine problems in the Medicaid program. The following problems in nursing home reimbursement were identified:

> 1. Because reimbursement increased with the number of points assigned to a patient (i.e., the patient's level of debility), nursing homes were encouraged to exaggerate the severity of the patient's condition. Proof that claimed services had actually been delivered was nearly impossible to obtain. For example, two points were assigned if a patient required some individual assistance when eating, and eight points were allowed for patients requiring "special and continuous supervision of a licensed nurse." Unless the state placed an inspector in the home, it was difficult to prove that these services were continuously provided.
>
> 2. Some facilities would accept only patients with point counts above a certain level. This made placement difficult. It also encouraged caseworkers to inflate point counts to facilitate placement.
>
> 3. The point system discouraged nursing homes from helping patients to become self-reliant.
>
> 4. The point system provided a disincentive for quality care, that is, because homes maximized profits by minimizing costs there was a possibility and incentive to cut costs by lowering the quality of care.[31]

To some extent, these objections were a reiteration of the critique made in 1968 by an ad hoc committee of representatives of major provider associations charged by DPA with developing an alternative payment formula.[32] The response to the analysis and recommendations of both the 1968 and 1974 special committees was identical. The point count system was not changed.

Regardless of the status of the point system, nursing home expenditures were being forced up by a change in federal regulations. Prior to 1974, the distinction between ICFs and sheltered care was

sufficiently blurred that Illinois was able to receive federal Medicaid funds for both types of facilities. In 1974, federal clarification of the definition of an ICF changed that and threatened the federal funding of sheltered care. Two particular problems arose. First, HEW required that all Medicaid patients residing in an ICF must receive medical care. Illinois responded by rewriting its regulations. The state stipulated the need for medical care existed when patients were incapable of administering their own medication. The attending physician was the only one required to indicate when a patient was in need of medical care. In spring 1975, all sheltered care patients were reevaluated and two thirds of them — approximately 11,000 patients — were upgraded to ICF care at an additional yearly cost of 13 million dollars, about 5 million dollars more expensive than if the state had disqualified the patients for Medicaid and picked up the entire cost of their care in a sheltered care facility.[33]

Reclassifying patients was easier, however, than reclassifying facilities. HEW required ICFs to meet the Life Safety Code provisions. In order for homes to stay in the program and continue to care for their "upgraded" patients, many facilities made the costly changes required to meet Life Safety Code standards.[34]

The upgraded ICF patients increased Medicaid nursing home expenditures, without introducing any new public patients into the system. More than that, the upgrading greatly increased the number of ICF patients thereby making any increases in the base rates more expensive than prior to the reclassification. The state responded to this new financial burden conservatively. In fact, between 1975 and 1976 the rate increases were so small, that the state had effectively placed a freeze on rates. Recognizing that some homes might be severely and adversely affected by the rate freeze, the state established a nursing home hardship board in January 1976. Although the board only operated for six months, it allowed 200 homes to appeal for rate increases and awarded 50 homes increases of up to fifty dollars per patient per month.[35]

The industry felt that the hardship board was insufficient, that rates had been too low for too long, and that the state did not seem willing to negotiate substantially higher rates. In October 1976, the executive director of the Illinois Association of Health Care Facilities

(the association representing the Chicago-based nursing homes) built a coalition of 400 homes from within his association and the five remaining nursing home associations to force the state to meet the coalition's demands.[36] The homes refused to admit Medicaid patients until rates were raised. The coalition felt the boycott would become increasingly effective with the onset of cold weather, winter sicknesses, and the rise in the demand for nursing home care. The leader of the boycott said that the average Medicaid rate of $17.12 a day was "at least five dollars too low."[37] "The state is putting nursing homes out of business," the industry charged. "If they (the homes) don't shut their doors now to Medicaid admissions, they're in danger of shutting their doors to everyone."[38] It was further claimed that 250 homes had gone out of business because Medicaid rates had not kept pace with inflation and that an additional 300 homes were in danger of closing.[39]

The boycott came to an abrupt end five weeks later. It was broken by the threat of antitrust action and the commitment by newly elected Governor Thompson to listen to the industry and act to "clean up the Medicaid mess."[40]

A CRITIQUE OF THE BOYCOTT CHARGES

It should be noted that while exaggerated, there was some truth in the industry's claims. First, rates did not appear to keep pace with inflation. Between January 1972 and March 1976, the Consumer Price Index increased by 36 percent while SNF and ICF rate increases in Chicago and downstate ranged from 13.1 percent to 18.5 percent respectively.[41] Although rate increases did not match inflation, the flexibility of point count reimbursement often allowed providers to increase their revenues by servicing patients requiring higher levels of care or limiting admissions to patients with higher points. The shift to higher levels of care was an effective method for homes to increase their net revenue if the payment/cost ratio for SNFs was greater than the ratio for ICFs. Between 1972 and 1976 the percentage of Medicaid nursing home patients receiving SNF care went from 8 percent to 23 percent.[42] In the high-cost Chicago area, the ratio of SNF patients to ICF patients was three times greater than down-

state.[43] The size of the shift to SNFs and the higher incidence of SNF care in high-cost areas suggest that the shift was not due to changes in the condition of the patients but was a way of increasing low reimbursement rates. Further, Chicago had an unexplainably higher average point count per patient than the rest of the state.[44]* If these unexplained points were unrelated to patient debility, then the classification system may have been used to circumvent low rates.**

Surveys by the industry and the state tended to substantiate the charge that Medicaid rates often did not cover costs. A study of a sample of sixty-seven facilities in 1975 indicated that forty-five homes showed average costs which exceeded Medicaid rates from $.20 to $13.17 per patient day with a median loss of $1.76 per patient day. In the remaining twenty-two homes, the Medicaid rate exceeded their average costs from $.20 to $5.74 per patient day with a median profit of $1.49. For the entire sample, however, there was average loss of $.94.[46]

Because private-pay patients often subsidize Medicaid patients, the study broke the homes down by percentage of Medicaid patients in the facilities (table 5). As the percentage of Medicaid patients increases, the home's private-pay rates must increase or the home must lower its costs. Steadily increasing rates would reduce the home's competitive position in the private market and result in fewer private patients. We would expect, therefore, that homes with a large percentage of Medicaid patients were more likely to operate at or near the Medicaid rates than homes with few Medicaid patients. The study tended to support this hypothesis.

* The ability of Chicago nursing home owners to require that new Medicaid patients have a high point count may have been directly related to the relative scarcity of beds in Cook County. As noted above, Cook County had 47 percent of the state's elderly population and only 35 percent of the nursing home beds. In the downstate areas, on the other hand, there may have been sufficient competition for patients that placement officials did not have to guarantee that a patient would have a minimum number of points (or at least a minimum may have been lower) in order to find a home willing to admit a Medicaid client.

** The differences in the point scores and SNF proportions could have been due also to changes in regulations during this period, changes in enforcement, or the questionable nature of the data.[45]

Table 5

Per Diem Profit and Loss per Medicaid Patient by Percentage: Medicaid Patients, 1975

Percentage Medicaid[a]	0-34%		35-52%		53-69%		70-100%	
	Profit	Loss	Profit	Loss	Profit	Loss	Profit	Loss
Number of facilities	4	9	4	13	6	11	7	7
Average profit or loss	+$1.03	-$2.86	+$1.36	-$1.42	+$1.95	-$2.21	+$2.30	-$1.90

Source: Illinois Economic and Fiscal Commission, Medicaid Costs and Controls (Springfield, Illinois, December 1976) p. 94.

a. Average percentage Medicaid patients for all facilities = 53%.

This evidence does not necessarily prove that the Medicaid rate was inadequate. Because the study was based on questionnaires mailed out to a much larger sample, there was reason to suspect self-selection among those who returned the questionnaire with those homes incurring the greatest losses having the greatest incentive to respond.* Further, the data did not distinguish between tax deductions which were not cash expenses (e.g., depreciation) and cash expenses which were not tax deductions (e.g., amortization). It would be possible, for example, to report large losses while experiencing a cash surplus.[48]

Even if the losses were "true" losses, they should be taken in context. Historically, nursing homes have operated in two markets — a public welfare market and a more lucrative private market. As long as Medicaid rates paid for some portion of the homes' fixed costs, proprietary operators would be willing to accept welfare patients. More precisely, as long as Medicaid rates were slightly in excess of the Medicaid patients' share of operating (variable) costs, private-pay patients paid for their portion of the operating costs plus

* The Illinois Economic and Fiscal Commission accepted that self-selection might have biased the sample results. However, they also felt that the following factors "lead [them] to believe that the questionnaire results are representative.

1. The questionnaires were not returned to the [state] but to the Illinois Health Care Association; IHCA turned the unopened envelopes over to the [state]. There was no mention that the questionnaires would be used for any purpose other than the development of comparative salary schedules for nonprofessional and nursing staffs.
2. Because county nursing facilities were reimbursed on a different basis, DPA had audited cost reports from them. The costs reported by facilities returning the questionnaire were quite comparable to the audited costs of the county facilities.
3. Several studies had shown that nursing costs should be about 33 percent of total costs. It was possible to determine nursing costs directly from the questionnaire and determine what percentage they were of total costs. For the entire sample, it was almost exactly 33 percent. At the very least, then, the reports were internally consistent.
4. A completely random sample of nursing facility inspection records were drawn from the DPH files. They showed no significant differences from the facilities in the sample in terms of scores on medical reviews, number of complaints, and so forth.[47]

all the remaining capital costs and profits, and the home could not solicit an additional private-pay patient, then it would pay proprietary homes to accept Medicaid patients. Nonprofit homes would have slightly altered incentives and would be more reliant on charitable subsidies.*

The charge during the boycott that 250 homes went out of business because of insufficient Medicaid reimbursement was countered by the Walker administration's claims that it had forced 253 substandard homes out of the market.[49] How does one determine whether the Medicaid rates were forcing disinvestment in the industry?

If the rates were inadequate, if they could not be incorporated into a workable financial strategy with private-pay revenues and charitable subsidies, then there should be some evidence of overall decline within the industry. Illinois, however, has witnessed just the opposite. Between 1972 and 1976, the number of facilities dropped from 1,094 to 953, but the number of beds increased by more than a third, from 75,069 beds to 97,589 beds.[50] The industry has changed rapidly. Facilities were larger than they used to be. More homes provide expensive services in modern fire-resistant structures than was the case in 1972. One of the things that has not changed, however, is that the nursing home industry continues to grow.**

THE COST-RELATED SYSTEM

While the state was coping with the boycott, it was also developing a cost-related reimbursement system as required by the 1972

* See chapter 4, "Operating Costs."

** A representative of the Illinois Health Care Association has argued that growth per se does not indicate that the rates were adequate. F. Lynn May stated that the growth may have been the result of (1) provider response to pre-1972 reimbursement rates and appears during the 1972-1976 period because of the lag between the decision to build and the actual completion of construction; (2) efforts by providers to build prior to enforcement of certificate-of-need requirements (Public Act 78-1156); and/or (3) anticipation of the federally mandated cost-related reimbursement system.[51] As a rejoinder, we would still argue that while these factors may have contributed to the growth, the expectation and realization of an adequate return is the prime motive for the growth of proprietary firms.

amendments to the Social Security Act. After consulting with the industry, Illinois submitted a plan to HEW in December 1976. Four months later, the HEW regional office in Chicago approved the system.[52] In the same month, an Illinois nursing home reimbursement bill (Senate Bill 1308) was introduced before the Eightieth General Assembly. S.B. 1308 was an industry bill using the language, principles, and methodology developed in a reimbursement proposal by the Illinois Health Care Association (IHCA) — the largest proprietary association in the state.[53] For example, both the bill and the IHCA reimbursement proposal required that (1) patient services be reimbursed on a more elaborate and exhaustive patient assessment device than the point system; (2) ancillary services such as drugs and restorative therapies be isolated from other service costs such as dietary and housekeeping costs (in recognition of the fact that not all patients receive ancillary services and the ancillary services have higher management costs associated with them); (3) depreciation on capital be reimbursed on the basis of replacement value rather than the generally accepted historic costs base; and (4) profit be based on a return of the (home's) total investment. In addition, S.B. 1308 also contained a provision prohibiting private-pay patients from subsidizing Medicaid patients. Given the existing level of subsidization ($.94 per day in 1975), this was perhaps one of the more costly provisions of the bill.*

S.B. 1308 was not an inexpensive package. One estimate projected an increase in state nursing home expenditures of $83 million.[54] The Illinois legislature was persuaded by a successful lobbying effort by the industry that the increase in expenditures was warranted. Some legislators also believed (incorrectly) that all the provisions of S.B. 1308 were required by federal law and regulation.[55] As a result, the legislature passed S.B. 1308.

Governor Thompson remained unconvinced that S.B. 1308 was necessary. In October 1977 he therefore exercised his power of amendatory veto. He made the mandatory provisions of the bill optional. The governor also directed the state to work with provider organizations to develop a new reimbursement system.

* See "A Critique of the Boycott Charges."

During the same time period (September 1977), HEW's central office raised some questions about the Illinois plan approved in April. The Washington office found the method for determining capital costs unacceptable and felt that the plan was too vague in other areas. The regional office was instructed to request clarification from the state.[56] Illinois submitted a revised plan in October 1977 and met with HEW staff to iron out differences. A third plan was submitted in early December 1977.[57] Again, HEW denied approval. HEW argued that the plan lacked sufficient specificity with regard to cost finding, audits, and definitions of allowable costs. HEW also found fault with the system's adjustment factors for imputed occupancy, inflation, and minimum wage increases; the use of the point system for nursing costs; and the use of separate reimbursement methods for state facilities and private facilities.[58] Illinois was asked to submit a new plan.

A December court decision in favor of the industry added a sense of urgency to gaining federal approval. The industry had brought suit against the state on the grounds that the Illinois point system was not a "reasonably cost-related" reimbursement system as required by federal law by July 1976. The courts agreed with the charges and ordered that if the state could not gain HEW approval by January 1978, then the first HEW approved plan submitted in April 1977 should be adopted.[59] Neither HEW nor the industry was particularly enamored with the April 1977 plan. Consequently, the state received an extension. In March 1978, Illinois submitted an amended plan and received HEW approval.

The approved system retained the point system but developed a sophisticated methodology for establishing the dollar value of a point and then applied it only to nursing costs. The remaining operating costs were reimbursed up to the cost ceiling established by the fiftieth percentile of SNFs and ICFs within a geographic area. Capital costs were determined by disaggregating homes by age and location and reimbursing according to the median group experience within each cell.

The state estimated that the new plan would increase the average per diem rate to SNFs and ICFs from $17.15 to an estimated

$19.55. The net impact on the state expenditures could be an additional $20 million for the second half of fiscal 1978,[60] approximately half of what it would have been had the state adopted the industry's plan (S.B. 1308).

Barring the federal requirements for a cost-related reimbursement, the point count payment mechanism would probably have remained unaltered. Point count reimbursement persisted because for relatively low rates, the state could place more severely impaired patients.* Even changes brought about by the federal requirements did not force replacement of the point count system but, rather, its refinement.

* Thomas Walsh, associate director of the Office of Health Finance, notes that the state's intent in maintaining the system has been to "pay for high need patients without losing control over reimbursement for low need patients (e.g., as would be the case if we simply set a high ceiling rate)."[61]

IV. ECONOMIC ANALYSIS

The 1978 Illinois reimbursement system establishes a prospective rate for each home independent of the home's actual costs. As such, Illinois had developed a complex, sophisticated variation of the flat rate system. There is a problem with using the term flat rate. As William Pollak has noted, "flat rate is often used to describe a system in which all facilities are paid the same per diem rate. This term, however, is inappropriate for many possible systems in which each home receives a different rate, but one which is independent of its own reported costs." We would agree with Pollak that his designation of "facility independent" rate is more accurate and clear.[62] Rather than interject his terminology, however, we will use the term "flat rate" but apply Pollak's definition of "facility independent" to it. Thus, the term "flat rate" will mean any rate that is not directly related to each facility's individual costs. We present the simple case of a uniform flat rate first so that we can examine the way it affects individual homes and the industry. Then we will examine the more complex Illinois system, which is basically a composite of multiple flat rates. We will analyze the way in which reimbursement in Illinois modifies the incentives of a uniform flat rate.

GENERAL INCENTIVES - UNIFORM FLAT RATE

Under a flat rate system, an operator maximizes his profits by minimizing his costs. The greater the difference between a home's costs and the flat rate, the greater the profits or losses. If the flat rate is based on providers' incurred costs, as it is in California, providers in the aggregate can increase future payments by increasing current costs. However, an individual provider's effect on average

costs is so small that in the absence of collusion he has little incentive to increase real costs. In fact, an increase in costs is penalized by a reduction in profit. A cost-based flat rate does create an incentive to increase costs per books, however, if this can be accomplished through disguising profits as costs, without increasing real costs.

While flat rate reimbursement may prompt cost-minimizing behavior in the proprietary home, it may give the appearance that the state is supporting excessive profits in some homes. This is because incremental changes in the rate result in large costs (or savings) and produce major responses by the industry. For example, if an increase in Medicaid beds is required, the state normally must increase the rate. As a result, it will encourage homes to either switch some existing beds from formally higher paying private patients to Medicaid patients and/or it will encourage the addition of new beds to the stock. Regardless of where the increase comes from, the cost to the state as the major purchaser will be in excess of the cost of the additional beds made available to Medicaid. For example, a state may have 1,000 Medicaid beds for which it pays $20 per bed per day. If the state wishes to expand its supply to 1,100 beds, it must raise its rate to $22 per day, the estimated cost the state must pay in order to encourage an entrepreneur to build and operate the 1,100th bed. When the state raises its rate to $22, it pays a $2 per patient day increase to the 1,000 preexisting homes. The cost to the state for attracting these 100 beds into the market is $2 x 1,000 plus $22 x 100 or $4,200. Thus, in this example, the additional 100 beds effectively cost the state $42 per day. Further, the increase in Medicaid rates will most likely bid up the private-pay rates, thereby increasing the rate at which private patients deplete their resources and become eligible for Medicaid. Finally, the impact of the new beds will not have a uniform effect on existing facilities because of differences in proximity to the new nursing home, differences in profit/nonprofit status, organization, and administrative expertise. Some homes will immediately feel the competitive pressure and will incur the costs necessary to maintain their patient census or incur the loss of patient revenues. On the other hand, some homes' costs will be unaffected by the additional beds, and consequently, the rate increase will be a bonus for them.

This discussion of the dynamics of flat rate pricing may shed some light on the recurrent charge that it is intrinsically unfair to

set rates at median cost because half the industry will then have costs in excess of that flat rate. From an economic perspective, that political attack on flat rate is overly simplistic. In the absence of barriers to entry, flat rates act as a marginal pricing mechanism. Over the long run they will equal the marginal cost of bringing the last Medicaid bed into production. This does not mean that the state consciously sets the rate with a target number of beds in mind, but that the effect of the flat rate, regardless of how it is set, is to attract investors until the cost of the least efficient bed brought into production equals the flat rate.

Nor do flat rates as a marginal pricing tool mean that owners will immediately increase the size of their homes by one bed for a given increase in the rate. The bed stock is the least flexible component of the nursing home industry. Investors may be willing to build new homes of only 100 beds or more, for example, or to add onto existing structures in units of 25 beds or more. Further, because of the time lag between the decision to build and the actual completion of the new beds, the response to an increased rate may not be seen until two or three years after that rate increase was first issued. Similarly, because nursing homes are single purpose structures functioning in heavily regulated sectors, an owner may find it difficult to exit immediately from the market (by either shifting the home to another use or selling). Thus the result of an effective decrease (in real terms) in the flat rates on the industry's supply of beds may not become apparent for a year or two after the rate changes. Further, incremental rate changes may be viewed as short-term phenomena, insufficient to produce any changes in the industry's bed supply. In this case the industry would adopt a wait and see posture, enjoy short-term gains (or absorb short-term losses) and act once the rate changes were perceived as being part of a long-term trend.

The decision as to how a firm will allocate its existing beds between Medicaid and non-Medicaid patients is directly linked to the relative revenue potential of both markets. In most instances, the allocative response by the homes could be more rapid than decisions to build or disinvest because the ability to reallocate is constrained only by the availability of unoccupied beds and the rate of patient turnover. Thus the state could experience a more immediate change

in the availability of Medicaid beds without any net change in the bed capacity of the industry.

Normally, extremely large profits throughout the industry would be a short-run phenomenon which would signal other investors to build nursing homes, increase competition, and reduce excessive profits. (This assumes that in addition to absence of barriers to entry the state actively monitors the financial condition of homes and acts as a prudent buyer. If the state increases rates without regard to actual cost experience, then the state can support excessive profits overtime.) On the other hand, average costs which over time are in excess of the flat rates reflect the use of charitable subsidies and the existence of more lucrative private-pay patients. Flat rates equal to median cost are unfair only if it is unfair to permit (1) differences in the style of operation between profit and nonprofit homes; (2) differences between the quality of care provided to some private-pay patients and level of quality provided to public patients; (3) subsidization of Medicaid patients by private-pay patients; and/or (4) intrastate differences in costs between urban and rural communities.

Operating Costs

A proprietary provider's sole source of profit under a flat rate is the difference between that rate and his average cost. Therefore, to maximize profit he will minimize costs. In terms of variable costs, this means limiting services, staffing levels, salaries, etc., to the lowest level necessary to retain licensure and certification.

What are the implications for quality of care? A definitive answer is impossible in the absence of a generally accepted definition of quality of care. A distinction can be made, however, between quality as defined in terms of the nature and appropriateness of medical services, nonmedical services, or the physical plant.[63] Certainly deficiencies in medical care will have a more immediate and undesirable effect than deficiencies in other types of services or goods. Medical care might therefore be considered the keystone to nursing home care. This does not mean that insufficient food or unheated rooms cannot lead to poor health but that beyond a certain point, nutritious meals and properly heated rooms cannot compensate for inadequate

medical care. Further, the problem of examining the effect that the flat rate has on each type of quality is compounded by the fact that increased reimbursement does not necessarily lead to an increase in quality and that unconstrained increases in quality of care are neither desirable nor necessary. Certainly the state would not wish to forgo supporting other public activities (such as education, welfare, or non-nursing home Medicaid expenditures), so that it could support whatever level of care the nursing homes decided to provide. Given these constraints and given that the state has a target level of quality (across each of the dimensions mentioned above) greater than that required by licensure and certification, the economic incentives under a flat rate system will be to efficiently maintain the lowest level of quality permitted by law and regulation. Thus, the quality of care may be less than targeted but at or above the level deemed minimally acceptable by the state.*

If there is no competition within the nursing home industry, that is, if every operator can maintain continuous 100 percent occupancy, there is no incentive to provide higher quality and more extensive services than required by the quality enforcement agency. However, the existence of competition will to some extent offset the incentive to minimize quality. First, because fixed costs do not vary with volume, an increase in occupancy results in a spreading of these costs over a larger population, that is, a reduction in average cost. Therefore, a provider must weigh the cost of increasing quality and scope of services against the potential for increased profits which may be realized if an increase in demand results in lower average total cost (unit cost). This argument becomes somewhat attenuated when placement decisions are placed in the hands of social workers or other third parties who may have more pressing priorities (e.g., rapid placement) than quality.

Second, independent of its effect on occupancy, the proportion of private-pay patients in a facility will affect profits. Private-pay patients typically pay more than Medicaid pays, demand more than Medicaid requires, and generate greater profits than Medicaid generates.

* Designating care the minimum level of acceptability does not mean that the care is inadequate. It merely indicates the base upon which other services or goods can be added.

If homes are to attract private patients, they must offer care at a level equal to or higher than other homes competing for those patients.

The strength of these incentives will vary with the level of reimbursement. The higher the payment rates, the greater the likelihood of competition, and thus the stronger the incentive to increase quality in order to attract patients. In other words, as long as entry is unrestricted, increases in the flat rate will attract new beds and theoretically produce quality increases over the long run. In practice, this effect will depend on the geographic dispersion of facilities (i.e., the addition of new beds to the stock in one region of the state will heighten competition for patients within that region), and on the array of factors other than the level of reimbursement (access to capital, nursing home scandal, etc.) which influences the decision to enter the nursing home market.

An increase in the level of reimbursement may affect demand as well as supply. If the income eligibility standard for Medicaid nursing home care is related to the Medicaid reimbursement level, a rate hike will serve to expand eligibility. The resulting increase in Medicaid demand will reduce the impact on quality of any supply expansion caused by the rate increase. Again, this effect is subject to geographic variation; for example, in areas in which a significant number of persons have incomes just above the existing reimbursement level, a rate hike will have a much greater impact on demand than in areas where the majority of elderly persons have incomes which place them either below or well above the reimbursement level. Thus, in practice, the extent to which an increase in the flat rate will spur an increase in nursing home quality will vary with location (proximity to new entrants), the strength of other constraints on supply expansion, Medicaid eligibility policy, income distribution within the elderly population, etc.

Flat rate reimbursement also creates incentives with respect to patient admission and care. The system rewards providers for selectively admitting patients for whom they can care at the lowest possible cost, that is, the "healthiest" (least impaired, least disruptive) patients. In California, for example, spokesmen for the state and the industry identified this incentive as one of the most significant disadvantages of their flat rate system.[64] California was not only concerned with

the hardship imposed on heavy care patients for whom nursing home beds could not be found, but also with the cost of keeping such patients in hospitals.[65]

Once providers have "creamed" these patients from the pool of persons seeking admission to a facility, the incentive is to care for them as cheaply as possible. While a healthy person will require less nursing care than one whose functioning is impaired,[66] the cost of retarding deterioration in patient condition (i.e., providing therapy and restorative services) may exceed the resultant savings in nursing care. Thus, to the extent that keeping patients healthy and rehabilitating impaired patients costs the operator more than it costs if he provided routine services only, the payment system encourages him to allow patient conditions to deteriorate.

The discussion so far has concentrated on the disadvantages of flat rate reimbursement; it also has significant advantages over a system in which rates vary with the individual provider's costs. As indicated, flat rates enable the state to retain tighter control over reimbursement expenditures. In addition, they are far easier to administer (thus reducing the state's administrative costs) and allow more accurate budgeting by the state and the provider. And finally, they create a strong incentive to providers to operate efficiently. Cutting back on operating costs does not necessarily result in a reduction in quality. The flat rate system undoubtedly induces operators to seek purchase discounts, eliminate wasteful administrative practices, encourage employee productivity, etc. To the extent that these efficiencies permit operators to spend more generously in areas directly related to patient care, the incentive to operate efficiently may benefit patients as well as the state.

Assuming that the objectives of nonprofit providers differ from those of proprietary providers, they can be expected to behave somewhat differently under the system. Proprietary providers seek to maximize profit; the objectives of nonprofit providers are less easily identified. The conventional wisdom is that nonprofit operations seek to minimize some unknown function of quality and quantity.[67] For example, a nonprofit institution serving a clearly defined, limited population (e.g., the members of a fraternal organization) may have no desire to expand so long as it can provide sufficient beds to meet

demand within that population, and thus its primary objective is to increase quality. Another provider may be willing to sacrifice quality in order to serve as large a population as possible.

From these objectives it follows that a nonprofit provider whose patient population is 100 percent Medicaid and who has no other source of income will seek to incur costs at a rate exactly equal to Medicaid's reimbursement. Higher average costs would put him out of business; lower costs would result in a surplus. Because of his nonprofit status this surplus could not be distributed, but would have to be put back into the operation thus increasing per patient expenditures to the level of the state's payment.

Few nonprofit operations, however, rely solely on Medicaid revenues. Most care for some private-pay patients and most have charitable contributions and endowments on which they can draw. Under these conditions they can be expected to pursue the targeted levels of quality and quantity as far as their various sources of income will allow. Assuming there is no limit to nonprofit providers' desire to expand beds and/or services, they can be expected to spend at rates in excess of the reimbursement level until the pool of charitable contributions allocated for the current period is depleted.

Capital Costs

Incentives facing a proprietary provider with regard to capital expenditures are the same as those outlined in the preceding sections: minimize costs subject to the conditions described above. If degree of facility maintenance and restoration and amount of land and square footage per patient can be used as quality measures in the area of capital costs, then providers can be expected to reduce quality, that is, allow facilities to deteriorate, build on the smallest tract of land possible, and keep square footage to a minimum, except to the extent that this results in lower occupancy and reduced private-pay revenues.

A flat rate payment system rewards efficiency with respect to capital expenditures as well as operating cost expenditures. Examples of efficient capital cost behavior which have no negative effect

on quality of patient life or care are seeking to obtain the lowest possible mortgage interest rate, accepting competitive bids on facility construction, and substituting labor for certain expensive pieces of equipment. Nonprofit providers could be expected to operate efficiently as well; savings could be used to increase quality and size. Again, if efficient capital cost behavior permits operators to spend more generously in areas directly related to patient care, the incentive to operate efficiently may benefit patients as well as the state.

The reimbursement system creates incentives for the financing of capital as well as for real capital investment. The investment decision requires not only the choice of a level of total investment (which determines an owner's assets) but also the apportionment of that investment between the investor's own and borrowed funds (which determines his equity).

Generally, if an owner borrows the money to finance his facility he may claim depreciation and the interest on his mortgage as allowable capital costs. If he invests his own money he may claim only depreciation. The decision to finance rests on a comparison of the mortgage interest rate (i.e., the cost of borrowing) with expected rates of return in other markets (i.e., the cost of investing in the nursing home).

THE ILLINOIS SYSTEM

The 1978 Illinois reimbursement method carried many of the positive incentives of a flat rate system while offering countervailing rewards to offset some of a flat rate system's disadvantages. It was a system which over the short run should have forced homes to become more efficient and more reliant on non-Medicaid subsidies (from private-pay patients, charitable trust, etc.). It also attempted to counteract the incentives for lowering quality and cream skimming. Over the long run, the stringency of the payment system including its failure to reimburse for a return on equity or profit would probably reduce the willingness of homes to participate in Medicaid and encourage disinvestment in the industry.

Operating Costs

Operating costs consisted of support costs and nursing costs. Before rates were calculated, however, reported operating costs were adjusted for occupancy, inflation, changes in the minimum wage, and location as follows:

Occupancy rates

If a home's occupancy rate was less than 93 percent (the 1977 median rate for the state) then its occupancy rate was recalculated to equal its actual occupancy rate plus one third the difference between its actual rate and 93 percent. By making the imputed occupancy rate greater than the actual rate, the state was able to reduce its per patient day costs (i.e., there were now more "patients" to spread costs over). The state claimed that the one-third factor was derived from studies on the impact of occupancy on operating costs. If a home's occupancy was equal to or greater than 93 percent, then its actual rate was used and costs were unadjusted.

From the state's perspective, low occupancy was undesirable unless the state wanted to encourage behavior which also contributed to low occupancy. A variety of factors other than discharges or deaths will result in empty beds: a relatively small number of elderly within the home's service area (or an excess supply of beds), high private-pay rates, poor quality care, and/or mismanagement. In addition, among those homes whose actual occupancy rate was 93 percent or less, the loss of a patient may have had a greater effect on smaller facilities than on larger ones. The extent to which this occurs is an empirical question. The desirability of this bias depends upon whether the state wants to encourage smaller facilities. Further, because a statewide median carried with it an incentive for homes with low occupancy rates to seek out patients in areas where the demand for care was greater, the occupancy adjustment encouraged greater allocative efficiency within the industry. Finally, given that the industry was primarily proprietary, there was little reason to suspect that excess variable costs would be incurred as occupancy

levels declined. The question was how do per patient variable costs respond to a decline in occupancy. While we should expect a total decline in variable costs, per patient variable costs may also change. If the per patient costs increased, "the State will pay something more than it would have to in an effectively utilized facility... Since we are required to pay only for efficiently operated facilities, there is no reason to assume that (the State) should pay for someone failing to fill his beds."[68]

The problem with the adjustment mechanism selected by the state was that it penalized all homes whose occupancy rates fell below the 93 percent level regardless of whether or not they took steps to reduce their operating costs. The state had three basic options to remedy this situation. It could have eliminated the occupancy limit but then it would have paid for all increases in average variable costs due to a home's decline in occupancy. It could have constructed a cap on costs — a per patient amount based on some imputed efficient use of a firm's capacity. This in turn raised a series of technical problems (depending upon whether each home has its own cap or was grouped with "similar" homes) which may have been difficult to solve and less equitable than the existing system. Finally, it could have restricted the application of occupancy limits to capital costs and assumed that variable costs would have continued to decline with a decrease in occupancy (and therefore occupancy limits for variable costs were not needed).

Inflation adjustment

Because the cost reports used to set the rate were between one and two years old, costs were increased to reflect inflation experienced since the submission of the reports. This was done by comparing the rate of inflation for nursing home costs from the two most recent cost report periods, dividing that by increases in the CPI during the same period. That ratio was multiplied times the projected CPI inflation rate. This adjustment recognized that nursing homes did not purchase the same mix of goods as those used to calculate the CPI.

Minimum wage

If minimum wage increases occurred, an adjustment in the rates would be made in areas where the shift in the minimum wage was likely to affect the wages nursing homes must pay over and above the increase in costs projected by the inflation adjustment. This adjustment attempted to assist those homes hit hardest by a minimum wage increase, that is, those homes which paid a number of their employees at the minimum wage and would be forced to increase their wages with changes in the law. As an example of how this would work, the regulations discussed the January 1, 1978 minimum wage increase to $2.65.

> The specific adjustment for this change is calculated by dividing the difference between the regional average nurse's aide salary updated for inflation as above, and $2.75 — ten cents more than minimum wage — by the updated minimum salary:
>
> $$\frac{\$2.75 - (\text{Updated regional average nurse's aide salary})}{(\text{updated regional average nurse's aide salary})}$$
>
> Where the updated regional average nurse's aide salary exceeds $2.75 per hour, no minimum wage adjustment is made. The resulting percentage is multiplied by the estimated amount of total expenses due to nonadministrative salary, based on the state's cost reports. The total expenses of each facility within the HSA are increased by that factor.

The industry objected to this adjustment on the grounds that minimum wage increases had "a ripple effect on all wages." Those facilities in areas such as Chicago where the lowest paying job paid more than $2.75 an hour would nonetheless be affected by the minimum wage increase but would not be reimbursed by the state.

One response to this argument was that homes with wages below the new minimum wage must increase their rates immediately and therefore should be compensated immediately. Although other homes will undoubtedly feel some of the impact of minimum wage increases, that impact will probably take place much less rapidly and will surface in the cost reports used to calculate Medicaid rates. The rate at which homes must adjust to the minimum wage was the critical

factor. The slower the rate, the less urgent the need to isolate wage increase from general inflationary trends within nursing homes.

A representative of the Department of Health also noted the following:

> In addition, while the ripple of minimum wage is required by management considerations within a facility there is no evidence that it continues to the general wage scale in a community. Some have argued that minimum wage reduces the number of jobs available, so that the surplus labor pool willing to work at the minimum wage may actually expand, making it easier for facilities in the region to hire at minimum wage.[69]

Location adjustment

Facilities' costs were clustered by health service area. (There were eleven HSAs in Illinois.) This grouping acknowledged differences in costs of inputs between regions and minimized regional advantages. After these adjustments were made, the operating costs were divided into support costs and nursing costs.

Support Costs

Support costs included laundry, dietary, housekeeping, utilities, and administrative expenses. They were reimbursed at actual cost up to the fiftieth percentile of all SNFs' and ICFs' facilities (except state MR facilities) in an HSA including those homes with no Medicaid patients. Facilities with support costs less than the fiftieth percentile would be reimbursed their costs plus one half the difference between their costs and the group ceiling.

The groupings of all SNFs and ICFs for support costs were justified on the basis that all facilities must provide these services and therefore support costs should not vary by level of care. Given however, that private rates were, on average, higher than Medicaid rates and that the quality of care delivered to non-Medicaid patients was

generally higher than that delivered to Medicaid patients,[70] we would expect that homes catering exclusively to non-Medicaid patients would have had higher support costs than would the homes servicing primarily Medicaid patients. Thus by including the few facilities which did not have Medicaid patients in the ranking for support costs, the state probably shifted the median cost ceiling upward. By excluding the few expensive state facilities for the mentally retarded (MR), however, the state probably shifted the median down. The extent to which all this affected the median is, of course, an empirical question.

Reimbursement for support costs carried with it the flat rate incentive for proprietary firms to maximize profits by minimizing costs. This incentive was attenuated somewhat because nursing homes operating below the ceiling received half the difference between their actual costs and the median. The incentive, however, to minimize costs remained. Its effect would be a function of how minimizing support costs affected quality and how quality in turn affected the home's ability to attract patients, particularly private-pay patients. We would also expect that nonprofits would spend to the ceiling — if they were not already over the median cost limit. If proprietary homes attempted to remain under the ceiling and if nonprofits incurred costs equal to or greater than the median costs, over time we would expect most of the nonprofits to be at or above the median cost.

Nursing Costs[71]

Nursing costs were reimbursed separately for each of four facility classifications: SNFs and ICFs, ICF-MR, SNF-Pediatrics, and state-run MR facilities. We shall restrict our attention to the SNFs' and ICFs' grouping because this grouping had by far the greatest number of homes within it, and the reimbursement technique applied was the most interesting of the four classifications.

The calculation of nursing costs attempted to address the differences in costs incurred by homes because of differences in their patients' conditions. It attempted to recognize the cost of acceptable quality care. Finally, it attempted to reverse the general incentive under a flat rate system for cream skimming the healthy patients. In order to do this, the state constructed a cost function for nursing

costs; that is, factors which were likely to affect nursing costs were identified (e.g., wages, patient debility, quality of care, etc.) and the function was then estimated by collecting cost data from the homes and regressing the independent variables (the factors thought to affect nursing cost) on nursing costs. As a statistical tool, regression analysis tests the impact that each factor has on nursing cost independent of all other factors. For example, if nursing costs were thought to be a function of quality of care, profit/nonprofit status of the homes, and patient mix, then regression analysis would examine how nursing costs change when quality of care changes but when ownership status and patient mix remain constant; how nursing costs change when ownership status changes but when quality of care and patient mix remain constant; and so on.

The Illinois system identified nonlabor inputs, wages, certification level of the homes, the patient point count, a quality score, ownership (county government, voluntary, profit) and the proportion of Medicaid in the homes as the factors likely to affect nursing costs. All but two of these factors were included in the regression. The cost of nonlabor inputs was not included because it was assumed to be uniform throughout the state. Because of the size of the sample, a wage-salary deflator calculated from nursing cost reports was used to adjust the regression's estimates for differences in regional labor costs.

The regression equation explained 60 percent of the observed variance in nursing costs. The equation was then "condensed into an administratively feasible formula" for the purposes of actual reimbursement. This was done by fixing the values of some of the variables to establish a base rate reflecting state preferences for a model home; for example, the high coefficients of county and voluntary homes, which indicated that these facilities were more expensive than proprietary homes, were disregarded on the grounds that "there is no compelling reason to believe that the state shares the objective functions of either of these groups nor to assume that the state should share in any inefficiencies which the higher costs represent."[72] Although initially it was argued that the proportion of Medicaid patients should be assumed to be 1.0 because "the state has no preference for providing a level of amenities unrelated to patient care which is in excess of that required to attract Medicaid

patients," the actual proportion of Medicaid patients (53 percent in 1978) was used in the equation. Finally, the quality index (a composite of ratings gleaned from licensing inspections, medical reviews, and private complaints and tested against the evaluation of state caseworkers and inspectors) was set equal to a hypothetical rating which indicated that good care was being provided. All of these factors were estimated as constants and added to the constant term in the equation. The condensed equation then assumed the following form:

$$R = \text{Constant} + A_1 \times P_1 + A_2 \times P_2 + A_3 \times S.$$

Where R = reimbursement for nursing care
P_1 = number of points through 17
P_2 = number of points over 17
S = 1 for a skilled bed, and 0 for all other circumstances.

As noted in the regulations,

> The multiple regression equation indicates that a reasonable estimate of increase in the daily cost of care for 1978 would be $.24 per point up to 17 points. Above 17 points, each additional point would be expected to add $.20 per day to cost. The regression also indicates that a reasonable estimate of the cost of providing a day of skilled care is $1.88 above the cost of a day of intermediate care. The resulting reimbursement equation is
>
> $$R = \$2.93 + \$.24P_1 + \$.20P_2 + \$1.88S.$$
>
> To illustrate how the reimbursement equation would be applied, consider a patient who is assigned 20 points by a Department of Public Aid caseworker upon entering a facility. Care would be reimbursed at
>
> | | |
> |---|---|
> | $2.93 | base rate |
> | 4.08 | first 17 points |
> | .60 | points from 18-20 |
> | $7.61 | |
>
> If in addition, the patient had a condition which required skilled nursing care and the patient occupied a skilled bed, reimbursement would be increased an additional $1.88.

> If the subject facility is in an area where the cost deflator equals 1.0, $7.61 for an intermediate patient or $9.49 for a skilled patient in a skilled bed would be the rate to be paid. If the deflator for the area was .9, for example, the rate would be multiplied by .9 to obtain the reimbursable rate — $6.85 in the case of the intermediate patient.
>
> It is worth pointing out that since all patients have some points, the actual minimum payment is larger than the base rate alone. For instance, 7 points is a very low point count for an ICF patient. This would, however, create a program reimbursement of $4.61. Likewise, the usual cut off between SNF and ICF is 25 points so an average minimum SNF nursing reimbursement would be $10.49.[73]

This approach to reimbursing nursing costs had several advantages. It recognized differences in patient disability, thereby attempting to counter the incentive present in the support components of the reimbursement system to cream skim the healthiest patients. It focused on a cost most likely to affect the quality of care received. And, it derived the cost estimate in a two-step process which carefully sets forth pertinent variables and a reasonable state policy toward those variables.

There were problems, however. Forty percent of the variance remained unexplained by the equation. This was due either to random fluctuations or a failure to capture critical variables. (Although, it should be noted that a regression equation as simple as the one employed, which explained 60 percent of the costs, offered a relatively good fit for cross-sectional data.) If unexplained variance was due to the omission of a critical variable then some concern should be voiced as to how this tended to reward or penalize homes and whether those sanctions were consistent with public policy. If the unexplained variance was due to random fluctuations, however, then the coefficients would be unaffected. The variance would be evenly distributed around the estimates thereby not introducing any systematic rewards or penalties. And the method for establishing reimbursement would be more flexible and explicit and therefore more fair than if costs were simply paid up to a given percentile of nursing home costs.

Nor does this technique eliminate the weaknesses of the point system itself. The industry objected to the continued use of the point count because

> the bulk of nursing and program costs are required (sic) by minimum standards and are not affected by patient point count...a statistical model based upon cost reports will not reflect staffing costs necessary to provide quality care (because)...actual staffing costs reported on the cost reports are artificially low, (the result) of years of reimbursement at below costs. (Finally), although staffing patterns are not required by law, the state has the capacity to develop guidelines for minimum staffing requirements to meet existing regulations.[74]

The industry's objections were inconsistent. On the one hand, they argued that minimum standards dictated most of the nursing and program costs and not the point count. If that were true, then the minimum standards were either high enough to meet the needs of patients with the highest possible number of points or some patients were not receiving the care they needed. In either case, the point count should have registered as an insignificant variable in the regression equation. This did not occur. In fact, the equation revealed just the opposite, that is, the point count was an "important and statistically significant predictor of operating cost." Further, it was difficult to argue that minimum standards dictated costs and then argue that there were no quantitative standards (i.e., staffing patterns). Thus, while the state demanded that certain types of personnel be in the homes, it only required that the staff be sufficient to perform the tasks at hand rather than specify specific staff to patient ratios. Without minimum staffing patterns, the industry could not argue that state standards were responsible for most costs.

The industry's most substantive charge was that costs were artificially low because of the reimbursement system and therefore it was improper to use current nursing home costs as a basis for future payment. In the old system, base rates were arbitrarily assigned. Although the points rose with the expected increase in care that was associated with an increase in debility, the points were not carefully related to the costs of providing a given service. For more than ten years, however, the industry had survived and expanded because of

its ability to use the point system. Thus, the regression was more likely to pick up the industry's response to the previous reimbursement system rather than the reliability of the point system as an independent indicator of patient-related costs. Distortions and problems with the point system may have produced distortions and problems within the industry. The costs, however, could have been artificially high in light of the incentive to admit patients whose characteristics produce a point count that was the least expensive to care for relative to all other ways of arriving at that given point count.

Thomas Walsh, associate director of the Office of Health Finance, discounted either effect noting that while the point count system posed a constraint, concern with that constraint was irrelevant because

a. County, voluntary, and homes which cater to the 40-50 percent of the market which are private payers are not constrained by state policies and our sample includes this entire range of cost and reimbursement experience.

b. We use this experience to estimate a relationship and reimburse according to that relationship. Even if 70 percent of the facilities were reimbursed too little to permit adequate care in the past, if we accurately estimate the relationship and reimburse at a level which permits good quality, the past underreimbursement is irrelevant.[75]

There were more basic problems with the point system other than its use of historic costs. In a critique prepared by Thomas Walsh and Mike Koetting (also of the DPH Office of Health Finance), they argued that a patient assessment tool such as the point system had the following four problems:

1. It was administratively complex and costly. It required that patients be frequently reevaluated at a cost in Illinois of $4 million a year.

2. Discretion on the part of caseworkers produced discrepancy in patient classification. It was open to individual shortcomings of caseworkers to inconsistency in the application of point count standards, to arbitrary or capricious disregard of those standards, and

to bribery by nursing home owners to increase points. In addition, there was a systemic and unexplainable difference of 15 percent between the average point scores between regions within the states.* If the measurement error is systematically related to variations in cost, then the estimating coefficients will be biased and specifically the coefficients related to the points will be biased toward zero. (In plain language, the coefficients become unreliable.) The state remedied this problem by establishing a monitoring system which flagged caseworkers, offices, and regions which deviated from expected point count patterns. Perhaps just bringing the problem to the attention of DPH was sufficient. Because of these actions and greater reliability of current data, interregional differences in the point count no longer existed in 1978.

3. Simple patient assessment techniques like the point count system "cannot capture all of the needs which can be expected to affect costs of operation. In this case, those patients whose needs are not well represented will have difficulty finding placement. The solution to this objection is obviously to expand the assessment tool. However, the more complex the tool, the greater the administrative expense and possibly the greater the degree of judgment required by caseworkers in evaluating patients."

4. There are questions as to how consistent the relationship of points are to each other in the assignment of levels of disability and the costs associated with those disabilities. If feeding a bedridden patient costs $2.00, but the points for that level of disability produce revenue of $2.50 a day, then the incentive is to keep the patient in bed. On the other hand, if a patient requiring daily colostomy irrigation costs $6.00 a day but produces revenue of $5.00 a day, then the incentive is to not accept patients with those needs or provide the service less frequently than is necessary. Thus, if the cost for performing a given service deviates from the revenue generated by the points, then the system will tend to either reward homes for keeping patients sick rather than curing them or deny patients necessary services because of insufficient payment.

* As we noted earlier, this could have been due to, in part, differences in the bed supply. See chapter 3, "A Critique of the Boycott Charges."

It was not clear how strong the cumulative incentive to let a patient deteriorate was under the point count system nor how that general incentive might be thwarted by assigning different points to levels of disability. Nor was the level of "preference" for certain disabilities clearly understood. If the points were seriously out of line, then they might have biased nursing home behavior in a direction inconsistent with public policy.[76]

The assumption, however, that the point count system necessarily provided a disincentive for improving patient condition was not supported by empirical studies and must be examined carefully. As Walsh properly observed

> The fact that some amount is being paid to care for specific conditions does not imply an incentive to either cure or retard progress. Only if payment less cost in the debilitated state is greater than payment less cost in the well state can an incentive be said to exist.
>
> [In addition] a disincentive may exist in any system which does not have an effective quality incentive. The factors which contribute to quality — getting staff to talk to and take an interest in patients, perform unpleasant tasks, use the proper procedures in treating patients, etc. — require performance of difficult management tasks. While it is relatively easy to increase costs, there is no assurance that those increases will result in better patient care. (A case in point is State institutions, where we have had enormous staffs for years, but complaints regarding care provided have led to a major deinstitutionalization movement.) Unless an attempt is made to explicitly measure quality and reward for its provision, there is no guarantee that management will be adequate, or will even receive reliable feedback regarding its inadequacies. In fact, the more lenient the reimbursement system, after the point where sufficient resources are provided, the greater the temptation to throw more resources at a problem and neglect fundamental management solutions. The point count system makes it more difficult to throw resources at a problem in facilities which provide care to patients with low care needs, and

> consequently draws attention to the quality issue. It is not clear, however, that the resulting care will be poorer than would be provided under an alternative system.
>
> [Finally,] despite all the discussion, no one has ever produced evidence that an effective disincentive to quality care exists. The criticism has appeal because it addresses "quality" which elicits a pavlovian response from a number of quarters. There is, for example, no evidence that Illinois patients are more debilitated or less often rehabilitated than patients of other states.[77]

In terms of the relative merits of the point system one must accept that reimbursement systems alone do not and cannot guarantee that an acceptable level of care would be provided or that all patients regardless of their condition would be accepted into a home. To use a well-worn phrase, adequate reimbursement is a necessary but insufficient condition for assuring acceptable care or access. All that can be expected is that reimbursement be structured in such a way that it complements other regulatory devices designed specifically to monitor and control quality and access. In view of this complementary objective, the point count system must be judged relative to other current options. The state, for example, could have used other patient assessment tools, linked reimbursement to the quality of the home (as measured by inputs and/or procedures) rather than the conditions of the patient, or refrained from incorporating either type of mechanism into the payment system. Of the three options, only patient assessment permitted the state to "tailor reimbursement" to the disability of the patients. This had been, and continues to be, an important state objective. To the extent that a patient assessment device accurately discriminated between levels of patient disability and reimbursed accordingly, it overcame two of the major objections to rates set independently of each facility's experience: it eliminated the economic incentive to cream skim healthy patients and dampened incentives to lower quality below acceptable levels.[78]

The states continued use of the point count system was based on its unsatisfactory experience with other patient assessment instruments (most notably PACE) and its belief that weaknesses in the point system, particularly in terms of "objectivity and completeness can be remedied by redesign." That redesign was under way in 1978.

Capital Costs

Capital costs include depreciation, interest expenses, and property taxes. These costs were grouped by five age of investment classifications and five geographic regions. The age of investment was used to adjust for differences in the financial markets over time. The geographic regions attempted to adjust for differences in the cost of inputs within a given time period.

For the initial year of the system (1978), the latest acquisition of an existing home prior to July 1, 1977 served as a basis for the grouping. The date of construction was not used because data on original construction were generally unavailable. July 1, 1977 was used as an arbitrary cut off because of a surge of financial transactions (sales, leases, etc.) which inflated costs in anticipation of a cost-related reimbursement system. Homes constructed after July 1, 1977 might be placed in different categories if "cost data indicate that such groupings are appropriate."

Once a home was classified, its grouping was not changed because of sale, refinancing, leases, etc. However, all new construction, renovation, or investment in capital was classified by date of purchase. Capital costs were adjusted for an imputed 93 percent occupancy rate or actual occupancy level, whichever was higher. Only straight line depreciation was allowed. An asset may be depreciated only once. If there was a change in ownership, only the useful life unclaimed by previous owners was recognized.

Once the capital costs per patient day were derived and disaggregated by joint age and location classifications, the median capital costs for each cell were calculated. Homes with capital costs at or below the median received the median. Those with costs in excess of the median would receive 80 percent of that excess up to 110 percent of the median. Capital costs in excess of 110 percent of the median would not be reimbursed.

Group medians were to be recalculated annually. However, as a means of containing costs, group rates would not be allowed to increase over 1978 costs by more than 125 percent of the change in the CPI over the 1978 CPI. This constraint was not placed on rate increases due to renovation or new construction.

For the individual home, this form of capital reimbursement had clear incentives. If the home had capital expenditures less than the median, it received a bonus. If costs were equal to the median, it met its costs. In either case, if all other costs were being met, the incentive was to stay in the program or expand participation in Medicaid. It should be noted that because there was no return on equity, there was a strong incentive for any owner with capital costs below the median to withdraw whatever equity he might have in the home (by refinancing his home up to the capital limit) and reinvesting that money in a more profitable venture. If the home's capital costs exceeded the median, it received a penalty which increased substantially for costs in excess of 110 percent of the median. The incentive was to minimize losses by either refinancing or altering the composition of the home's patient census. Refinancing was desirable if current mortgage terms were better than the terms under which the existing mortgage was issued or, if by increasing the percentage of capital costs apportioned to interest expenses (and thereby decreasing the percentage apportioned to amortization), the tax savings exceeded the losses incurred under the Medicaid capital reimbursement. The latter might be advantageous if refinancing would result in nonreimbursable interest expenses and amortization costs in excess of depreciation less than those expenses under the existing mortgage. The home could also minimize the effect of the cap by altering its patient composition and increasing the proportion of non-Medicaid patients. This could be done by actively recruiting private patients, refusing to accept new Medicaid patients, or dropping out of the Medicaid program altogether. The intensity of the response would be a function of total losses on a Medicaid patient (and not merely losses on the capital component of the reimbursement system) and the existing level of private-pay and/or charitable trust subsidies. It should be noted, that if total losses persist after refinancing and shifts in patient composition, the incentive would be to cut back on the more flexible operating costs; that is, insufficient capital reimbursement may cause a decline in quality of care.

The fixed historical base and useful life of a home should have two effects: it should eliminate any incentive for trafficking (the selling and reselling of property at inflated prices), and it should affect older facilities in less favorable fashion than newer ones. The latter would occur because median capital payments would probably

decline in real dollars over time. The net effect might be rapid disinvestment of older homes well before they reach the end of their forty-year useful lives.*

Any additional impact of this form of capital cost reimbursement on the industry depended on how widely dispersed capital costs were around the median. It was quite possible that the costs for all the homes fell within 10 percent of the median amount. If there was a wide dispersion around the median, however, it is possible to speculate about what types of homes would be most affected by the reimbursement system by examining two major factors which would affect capital costs and which were not adjusted for by the payment mechanism. They are (1) the cost of purchasing the capital (mortgages, refinancing arrangements, etc.) and (2) the physical quality and size of the home and the location and size of the land.

Mortgage payments are a function of the principal borrowed, the interest rate agreed upon, and the length of the mortgage. For any given loan, if the interest rate is increased or the length of the mortgage shortened, then the payments required to amortize the loan are increased. Similarly, if the interest rate is reduced or the length of the mortgage increased, the mortgage payments are reduced.

Within any of the age/location categories, then, those homes with mortgage or refinancing terms which had relatively lower interest rates or longer maturation periods would also have lower per capita costs. This should favorably assist in positioning them relative to other homes. Those homes who had comparatively poor financial arrangements may find themselves well above the median.

It was not unreasonable for the state to expect homes to negotiate the least expensive mortgage possible. Nor was it unreasonable to assume that within given time periods, homes should have received financing under similar conditions. Reimbursement up to 110 percent of the median costs implicitly suggested these expectations. The system, however, also suggested a bias against homes whose physical

* Disinvestment here refers to a nonpublic owner removing his home from the nonpublic sector by abandoning it (which in some states places the home in public receivorship) or by modifying or selling the home and the land it is on for non-nursing home purposes.

plant and land exceeded licensing and certification requirements and thus cost more than homes which used the same quality inputs but which were built to meet only the minimum standards. While this appeared to be a straightforward relationship, the market apparently behaved differently than expected; that is, the state had been unable to discern any significant relationship between bed size or square foot per bed and capital costs.[79]

Finally, while we may discuss the intricacies of individual components of the reimbursement system, the final decision as to whether a home was maintained or sold did not rest with an isolated part of the capital cost reimbursement methodology nor for that matter with capital cost reimbursement alone, but with total reimbursement. If total reimbursement was sufficient to meet costs plus provide an adequate rate of return, then the industry would grow.

V. CONCLUSION

The point system was the most distinguishing and controversial characteristic of the Illinois reimbursement system. It was administratively costly, subject to caseworker discretion, and admittedly incapable of capturing all the factors which would affect costs. The point system, however, did allow the state to link patient disability to reimbursement, and the system attempted to overcome incentives to cream skim the healthiest patients. The methodology for deriving the dollar value of the points was sound and reasonable. The state felt that the point system was clearly superior to a payment mechanism which failed to recognize differences in patient characteristics and that deficiencies within the point system could be and were being rectified.

The remaining portion of the Illinois rate was based upon the median costs of support and capital services among groups of similar homes. This rate setting approach carried with it the incentives and disincentives of a flat rate. It was an approach the state felt was appropriate given the nature of the services they were purchasing. Indeed, as long as the homes were able to incorporate the total fees received from the state into a workable financial strategy with payments from private-pay patients and/or charitable subsidies and as long as the state was able to assure quality of care and gain access to a sufficient number of beds for Medicaid patients, then the Illinois system could be labeled efficient and successful.

In summation, then, Illinois has constructed a flexible and innovative approach to nursing home reimbursement. It permits continual monitoring and adjustment of the relationship the reimbursement system has to individual patients and to the total patient population

as well as to individual homes and the industry as a whole. The reimbursement system has produced a relatively rare situation where the state felt that costs were related to the care required by the patient, and where the state was able to contain costs.

NOTES

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2. Illinois Economic and Fiscal Commission, Medicaid Costs and Controls: An Analysis (Springfield, Illinois, December 1976), p. 8.

3. Memorandum from Karen Moe to Tom Storer, pp. I-5, I-6.

4. Ibid., pp. I-11, I-13.

5. Chicago Tribune, February 27, 1971, p. 1; February 28, 1971, p. 1; March 1, 1971, p. 1; March 2, 1971, p. 1; March 3, 1971, p. 1; March 4, 1971, p. 1.

6. Chicago Tribune, March 6, 1971, p. 1; March 9, 1971, p. 1.

7. Chicago Tribune, March 2, 1971, p. 1.

8. Chicago Tribune, March 5, 1971, p. 1.

9. Chicago Tribune, March 3, 1971, p. 1.

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12. Chicago Tribune, March 10, 1971, p. 3.

13. Chicago Tribune, March 16, 1971, p. 1.

14. Chicago Tribune, March 3, 1971, p. 2.

15. Memorandum to the Legislative Advisory Committee to the Illinois Department of Public Aid from Neil Gaynes, executive director of the Illinois Association of Homes for the Aging, March 14, 1971, p. 11.

16. United States Senate, Special Subcommittee on Aging; Subcommittee on Long-Term Care, "Nursing Home Care in the United States: Failure in Public Policy, Introductory Report" (Washington, D.C.: Government Printing Office, December 1974), p. 77.

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27. Ibid.

28. Michael Barone, Grant Ujifuser, and Douglas Matthews, The Almanac of American Politics, 1978 (New York: E. P. Dutton: Sunrise Books, 1977), p. 220.

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30. "A Problem with the Department of Public Aid: Comparative Study" (Illinois Legislature, undated fact sheet).

31. Chicago Tribune, December 4, 1974.

32. Illinois Association of Homes for the Aging, Special Bulletin No. 2, "Public Aid Payments to Illinois Homes for the Aged" (Springfield, Illinois, January 29, 1971).

33. Illinois Economic and Fiscal Commission, Medicaid Costs and Controls: An Analysis (Springfield, Illinois, December 1976), pp. 81-82.

34. Ibid.

35. Interview.

36. Chicago Tribune, October 6, 1976, section 3, p. 8.

37. Ibid.

38. Ibid.

39. Ibid.

40. Chicago Tribune, November 11, 1976, section 3, p. 16; Interview.

41. Illinois Economic and Fiscal Commission, p. 95.

42. Ibid., p. 83.

43. Ibid., p. 92.

44. Ibid.

45. Correspondence from Thomas Walsh to Bruce Spitz and Jane Weeks, December 14, 1978.

46. Illinois Economic and Fiscal Commission, p. 94.

47. Ibid., p. 96.

48. Ibid.; Sherman Maisel and Stephen Roulac, Real Estate Investment and Financing (New York: McGraw Hill Book Company, 1976), pp. 354-376.

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50. Personal communication, Illinois Department of Public Health.

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52. Illinois Department of Public Aid, "Cost-Related Reimbursement for Group Care Services" (Springfield, Illinois, January 10, 1978).

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57. Ibid.

58. Ibid.; Memorandum from Henry Spiegelblatt, director, Division of Policy and Standards, Medical Services Administration to Ralph Detloff, acting regional Medicaid director, Chicago, August 23, 1977.

59. Illinois Health Care Association et al. v. Arthur Quern et al., U.S. District Court, Northern District of Illinois, Eastern Division, No. 77 C 1109, Memorandum Opinion and Order, December 1977.

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71. This section benefited greatly from observations by William Scanlon.

72. Thomas Walsh and Mike Koetting, "Patient Related Reimbursement for Long Term Care" (unpublished, undated), p. 8.

73. Illinois Title XIX State Plan Amendment Attachment 4.19-D.

74. Correspondence from F. Lynn May for the Illinois Health Care Committee to Milton DeZube, Division of Policy Standards, Medicaid Bureau, Health Care Financing Administration, Department of Health and Human Services, January 24, 1978.

75. Correspondence from Thomas Walsh to Bruce Spitz and Jane Weeks, December 14, 1978.

76. Thomas Walsh and Mike Koetting, "Patient Related Reimbursement for Long Term Care," pp. 2-a, II.

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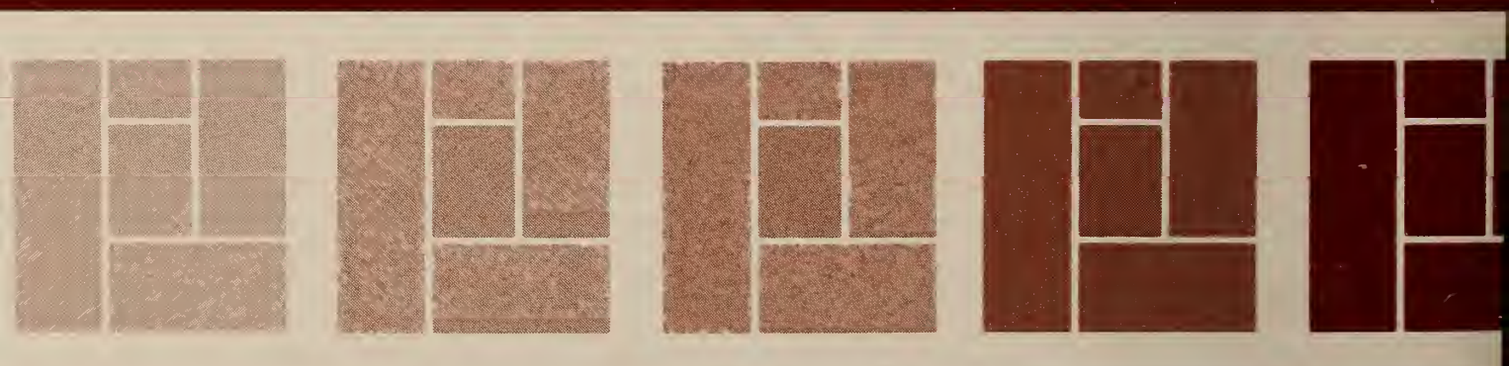

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